

4633  
CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Dorchester</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cambridge</u>		LENGTH OF STAY (in this place) <u>3 months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cambridge</u>		13	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Queen Ann Avenue</u>				STREET ADDRESS (If rural give location) <u>Queen Ann Avenue</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>MILDRED SMITH ALDRIDGE</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>MAY 26 19 55</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>4-23-1906</u>	
				9. AGE last birthday: <u>49</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Bookkeeper</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Appliance Store</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
						12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Edward T. Smith</u>				14. MOTHER'S MAIDEN NAME: <u>Bertha Phillips</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY No. <u>not known</u>		17. INFORMANT & ADDRESS: <u>Mrs. James C. Johnson : Cambridge, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>LYMPHOMA</u>						6 YEARS	
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>2</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4 JULY 19 49</u> , to <u>19 MAY 19 55</u> , that I last saw the deceased alive on <u>19 MAY 19 55</u> , and that death occurred at <u>9:30 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Halter E. Hunby Jr. M.D.</u>		ADDRESS <u>Cambridge, Dorch. Md.</u>		DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5-27-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Cambridge Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5-27-55</u>		REGISTRAR'S SIGNATURE <u>John M. ... M.D.</u>		24. FUNERAL DIRECTOR <u>LeCompte Funeral Service</u>		ADDRESS <u>Cambridge, Maryland</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 2 1965

BUREAU V. S.

4674

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04595

## CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Dorchester</b>		MARYLAND		STATE <b>Maryland</b> COUNTY <b>Dorchester</b>			
CITY (If outside corporate limits, write RURAL, OR and give nearest town) <b>13 Cambridge</b>		LENGTH OF STAY (in this place) <b>Life</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>13 Cambridge</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>67 Cambridge-Md. Hospital</b>		STREET ADDRESS (If rural give location) <b>151 Washington Street</b>					
3. NAME OF DECEASED: (First) <b>STANDIFER</b> (Middle) <b>ASKINS</b> (Last)		4. DATE (Month) (Day) (Year) OF DEATH: <b>May 27, 1955</b>					
5. SEX: <b>Male</b>	6. COLOR OR RACE: <b>Negro</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Single</b>	8. DATE OF BIRTH: <b>May 18, 1955</b>	9. AGE last birthday yrs. <b>8</b>	IF UNDER 1 YEAR Months <b>8</b>	IF UNDER 24 HRS. Days <b>8</b>	Hours <b>8</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>None</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>None</b>		11. BIRTHPLACE (State or foreign country): <b>Cambridge, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME: <b>Robert Scoggins</b>				14. MOTHER'S MAIDEN NAME: <b>Geraldine Allen</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>None</b>		16. SOCIAL SECURITY No. <b>None</b>		17. INFORMANT & ADDRESS: <b>Geraldine Allen, Cambridge, Md.</b>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <b>061X Tetanus</b>						<b>18 hours +</b>	
ANTECEDENT CAUSE (B) <b>Lobar pneumonia, bilateral</b>						<b>18 hours +</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <b>Dehydration + Mal nutrition</b>						<b>2 days +</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <b>0</b>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY—street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>5-26</b> , 1955, to <b>5-27</b> , 1955, that I last saw the deceased alive on <b>5-27</b> , 1955, and that death occurred at <b>11:45 P. M.</b> from the causes and on the date stated above.							
SIGNATURE <b>Eldridge H. Wofford</b>		M. D.		ADDRESS		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>5/29/1955</b>		NAME OF CEMETERY OR CREMATORY <b>Waugh Cemetery</b>		LOCATION (City, town, or county) (State) <b>Cambridge, Maryland</b>	
DATE REC'D BY LOCAL REGISTRAR <b>May 31, 1955</b>		REGISTRAR'S SIGNATURE <b>John Mace, M.D.</b>		24. FUNERAL DIRECTOR ADDRESS <b>Herbert M. St. Clair, Jr., Cambridge, Md.</b>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-53

1055242356

BUREAU V. S.

JUN 3 1955

RECEIVED

4624

## CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>rural Cambridge</u>		LENGTH OF STAY (in this place) <u>5 mo.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Salisbury</u>		<u>RURAL</u> <u>22X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>16 Eastern Shore State Hospital</u>				STREET ADDRESS (If rural give location) ✓			
3. NAME OF DECEASED: (First) (Type or Print) <u>JOHN</u>		(Middle) <u>WILLIAM</u>		(Last) <u>BAKER</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>May</u> <u>11</u> <u>19 55</u>	
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>10/7/78</u>	9. AGE last birthday <u>76</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Noble Baker</u>				14. MOTHER'S MAIDEN NAME: <u>Lavenia Wyatt</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>unk. 9</u>		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <u>Eastern Shore State Hospital records</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Chronic Myocardial degeneration with</u>							
ANTECEDENT CAUSE (B) <u>generalized arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/9</u> , 19 <u>54</u> , to <u>5/11</u> , 19 <u>55</u> that I last saw the deceased alive on <u>5/11</u> , 19 <u>55</u> , and that death occurred at <u>11:45</u> AM, from the causes and on the date stated above.							
SIGNATURE <u>Thomas F. Dudge</u>				ADDRESS <u>M. D. E.S.S. Hospital, Cambridge, Md.</u>		DATE SIGNED <u>5/11/55</u>	
23. BURIAL, CREMATION, OR REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>5-13-1955</u>		NAME OF CEMETERY OR CREMATORY <u>JERUSALEM METH. CEM.</u>		LOCATION (City, town, or county) (State) <u>PARSONSBURG, MD.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3-12-55</u>		REGISTRAR'S SIGNATURE <u>John Macer Jr. M.D.</u>		24. FUNERAL DIRECTOR <u>Thomas F. Walker</u>		ADDRESS <u>Salisbury, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 16 1955

BUREAU V. S.

4605

## CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Dorchester</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Dorchester</u>
CITY (If outside corporate limits, write RURAL or and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
X TOWN <u>Cambridge (Rural)</u>	<u>Life</u>	OR TOWN <u>Cambridge (Rural)</u>	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>RFD #3</u>		STREET ADDRESS (If rural give location) <u>RFD # 3</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
(Type or Print) <u>THOMAS E. BENNETT</u>		OF DEATH: <u>MAY 7 1955</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>8-19-1872</u>
9. AGE last birthday		IF UNDER 1 YEAR	
<u>82 yrs.</u>		Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Waterman</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Fishing Indust.</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John D. Bennett</u>		14. MOTHER'S MAIDEN NAME: <u>Hester Marshall</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
<u>unknown</u>		17. INFORMANT & ADDRESS: <u>Mrs. Susie Bennett: Cambridge RFD# 3, Md.</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Coronary infarction</u>			<u>5 min</u>
ANTECEDENT CAUSE (S) DUE TO (B) <u>Arteriosclerotic</u>			<u>5-6 wks</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Arteriosclerotic CVD</u>			<u>yes</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. TIME (Month) (Day) (Year) (Hour) OF INJURY		21F. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>March</u> , 1955, to <u>May</u> , 1955, that I last saw the deceased alive on <u>May 7</u> , 1955, and that death occurred at <u>9:00</u> A.M., from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>5-9-55</u>	
ADDRESS <u>Cambridge</u>		M. D. <u>Cambridge</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5-9-1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Sewards Cemetery</u>		LOCATION (City, town, or county) (State) <u>James, Maryland</u>	
24. FUNERAL DIRECTOR <u>LeCompte Funeral Service</u>		ADDRESS <u>Cambridge, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>May 10, 1955</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
MAY 11 1955  
BUREAU V. S.



MARYLAND

04598  
STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

Reg. Dist. No. 111

4625

1. PLACE OF DEATH COUNTY <u>Spencer</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Dor</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Secretary</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Secretary</u>	
TOWN <u>39th</u>		TOWN <u>Secretary</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Minnie</u> (First) <u>Leannette</u> (Middle) <u>Coulbourne</u> (Last)		4. DATE OF DEATH (Month) <u>5</u> (Day) <u>19</u> (Year) <u>1957</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED <u>Married</u>		8. DATE OF BIRTH <u>12/31/1897</u>	
9. AGE last birthday <u>59</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Elijah Hughes</u>		14. MOTHER'S MAIDEN NAME <u>Jennie (Unknown)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Darryl D. Secretary, Md</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause <u>Mutastatic adenocarcinoma</u>		
(b) Antecedent cause(s) <u>source adenocarcinoma Cervix</u>		
(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>Blatant Cordotomy</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death		
19a. DATE OF OPERATION <u>2/4/57</u>	19b. MAJOR FINDINGS OF OPERATION <u>Adenocarcinoma cervix</u>	20. AUTOPSY? <u>Yes</u> <input type="checkbox"/> <u>No</u> <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/18, 1955, to 5/19, 1955, that I last saw the deceasedalive on 5/19, 1955, and that death occurred at 11:30 p.m., from the causes and on the date stated above.SIGNATURE D. B. Banks, M.D. (Degree or title) ADDRESS Cambridge, Md DATE SIGNED 5/19/55

23. BURIAL, CREMATION REMOVAL (Specify)	DATE <u>5/22/55</u>	NAME OF CEMETERY OR CREMATORY <u>East New Market</u>	LOCATION (City, town, or county) <u>East New Market, Md</u>	(State) <u>Md</u>
DATE REC'D BY LOCAL REG <u>5-21-55</u>	REGISTRAR'S SIGNATURE <u>Elizabeth C. Smith</u>	24. FUNERAL DIRECTOR <u>Leath P. H. Hough</u>	ADDRESS <u>East New Market, Md</u>	

MARGIN RESERVED FOR BINDING

RECEIVED

MAY 25 1965

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4626

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04599

## CERTIFICATE OF DEATH

Reg. Dist. No. 110

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Dorchester</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Hurlock, Rural.</u>				OR TOWN <u>Hurlock, Rural.</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
107				1			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH.			
Mary Eliza Dennis				May 4th. 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Female	Colored	Married	Jan. 6th. 1909	46 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Laborer		Cannery, Home.		Maryland.		U.S.A.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Thomas Pinckett.				Daisy Lowbray.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
				220-01-7913		Mrs Daisy Cornish, Vienne, Md.	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
171X						5 yrs	
IMMEDIATE CAUSE (A)							
Generalized Corcinomatosis							
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.						8-9 m d	
DUE TO							
Corcinoma of Cervix							
DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 11/9 1954, to May 4, 1955, that I last saw the deceased alive on May 2, 1955, and that death occurred at 645P M. from the causes and on the date stated above.							
SIGNATURE		M. D.		ADDRESS		DATE SIGNED	
[Signature]		M. D.		[Signature]		5/5/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		May 7 1955		Thompstontown Cemetery		Hurlock, Md. R.F.D.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
May 7 - 1955		Charles W. Hastings		J.J. Frampton & Son.		Federalburg, Md.	

18 10/20/1911

18 10/20/1911

4606

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. 4600

No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Dorchester</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
13 TOWN <u>Cambridge</u>				TOWN <u>Cambridge</u>		13	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cambridge Maryland Hospital</u>				STREET ADDRESS (If rural, give location) <u>Oakley Street</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>GAILDINE MOORE GOLIT</u>				<u>MAY 21 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>White</u>	<u>Divorced</u>	<u>4-27-1923</u>	<u>32</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>On None</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
18. FATHER'S NAME: <u>Ausbrey L. Moore</u>				14. MOTHER'S MAIDEN NAME: <u>Madaline Tregoe</u>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>none</u>		17. INFORMANT & ADDRESS: <u>Ausbrey L. Moore: Cambridge, Maryland</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				INTERVAL BETWEEN ONSET AND DEATH			
824.X Immediate cause (a) <u>Fract of cervical vertebrae &amp; lumbar vertebrae</u>				15 minutes			
Antecedent cause(s) (b) <u>Compound fract of left leg</u>				15 minutes			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>Compound fract of left hip</u>				15 minutes			
DISEASE OR CONDITION CAUSING DEATH: <u>Avulsion of skin &amp; subcutaneous tissue over left hip &amp; gluteal region</u>				15 minutes			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH:							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>fract road</u> )		21c. (City or town) (County) (State)			
<u>RT # 50</u>		<u>Dorchester</u>		<u>Ind.</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>5 21 55 1 P.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Jumped out of moving truck &amp; then struck by car while lying in road</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Defted R. Maryanov</u>		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED <u>5/25/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>May 24, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>5-24-55</u>		REGISTRAR'S SIGNATURE <u>John Mace M.D.</u>		24. FUNERAL DIRECTOR <u>LeCompte Funeral Service</u>		ADDRESS <u>Cambridge, Maryland</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53



04601

MARYLAND

STATE DEPARTMENT OF HEALTH

4677

## CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Dor.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) 13 TOWN <u>Cambridge</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Ellists</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00		STREET ADDRESS (If rural, give location) 1	
3. NAME OF DECEASED (Type or Print) <u>Bethania</u> (First) <u>-</u> (Middle) <u>Grady</u> (Last)		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>5</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Widowed</u>	8. DATE OF BIRTH <u>6/16/1871</u>
9. AGE (last birthday) <u>83</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. FATHER'S NAME <u>Robert Smith</u>		12. MOTHER'S MAIDEN NAME <u>Margaret Tilly</u>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (If year, give war or dates of service) <u>Yes, no, or unknown</u>		14. SOCIAL SECURITY NO. <u>Leon Gray, East New Market, Md.</u>	
15. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
420. Immediate cause (a) <u>Coronary infarction</u>			<u>2 hrs.</u>
Antecedent cause(s) (b) <u>Atherosclerosis CVD</u>			<u>yes</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Pneumonia RLL</u>			<u>1 wk</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>6/13/55</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>May 2, 1955</u> , to <u>May 4, 1955</u> , that I last saw the deceased alive on <u>May 4, 1955</u> , and that death occurred at <u>6:13 P.m.</u> , from the causes and on the date stated above.			
SIGNATURE <u>J. Baumann Sr.</u>		DATE SIGNED <u>5-8-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>Ellists</u>	
DATE REC'D BY LOCAL REG. <u>5-12-55</u>		24. FUNERAL DIRECTOR <u>John Macmillan</u>	
REGISTRAR'S SIGNATURE <u>John Macmillan</u>		ADDRESS <u>East New Market, Md.</u>	

MARGIN RESERVE FOR BINDING

ROBERT V. S.

1008



1. PLACE OF DEATH COUNTY <u>Dorchester</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Dor.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (If less than one year)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	/
3. NAME OF DECEASED (First) <u>Herman</u> (Middle) <u>Douglas</u> (Last) <u>Hurley</u>		4. DATE OF DEATH (Month) <u>5</u> (Day) <u>18</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>7/24/1887</u>
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	12. CITIZEN OR NAT. COUNTRY?
<u>Electrician</u>		<u>Maryland</u>	<u>U.S.A.</u>
13. FATHER'S NAME <u>Elijah Hurley</u>		14. MOTHER'S MAIDEN NAME <u>Marie Horseman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Maria Gray Elliott, Md</u>	
(If year, give war or dates of service)			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
453.3 Immediate cause		(a) <u>Cerebral thrombosis</u>	
Antecedent cause(s)		(b) <u>Arteriosclerosis</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(c) <u>Peripheral Vascular Disease</u>	
II. OTHER SIGNIFICANT CONDITIONS		Raynaud's Disease	
Conditions contributing to the death but not related to the disease or condition causing death.		Interval Between Onset and Death <u>1 hour</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour)		HOW DID INJURY OCCUR?	
OF INJURY m. While at Work [ ] Not While At work [ ]			
22. I hereby certify that I attended the deceased from <u>10/29</u> , 19 <u>52</u> , to <u>5/18</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5/18</u> , 19 <u>55</u> , and that death occurred at <u>11:30 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u>		ADDRESS <u>Cambridge Md</u>	
DATE SIGNED <u>5/19/55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>Elliotts</u>	
DATE <u>3/21/55</u>		LOCATION (City, town or county) (State) <u>Elliotts Md</u>	
DATE REC'D BY LOCAL REG. <u>5/21/55</u>		REGISTRAR'S SIGNATURE <u>Elyabeth Craft</u>	
		24. FUNERAL DIRECTOR <u>Wm Luth S. Kellough</u>	
		ADDRESS <u>East New Market, Md</u>	

ROBERTO A. S.

1965

4698

## CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH.		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Dorchester</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Dorchester</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cambridge</u>	LENGTH OF STAY (in this place) <u>1 day</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bishops Head</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cambridge Maryland Hospital</u>		STREET ADDRESS (If rural give location) <u>P.O.</u>	

3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <u>GEORGIA A. JONES</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>MAY 25 19 55</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>8-20-1876</u>
9. AGE last birthday: <u>78</u> yrs.		10. MONTHS: <u>1</u>	11. DAYS: <u>25</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>	11. BIRTHPLACE (State or foreign country): <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME: <u>George Wingate</u>	
14. MOTHER'S MAIDEN NAME: <u>Virginia Fallen</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS: <u>Miss. Jennie Jones : Bishops Head, Md.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A)	<u>Coronary occlusion</u>	<u>2 days</u>
ANTECEDENT CAUSE (B)	<u>Coronary Heart Disease</u>	<u>7 yrs.</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION: <u>0</u>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5/25/55, 1955, to 5/25, 1955, that I last saw the deceased alive on 5/25, 1955, and that death occurred at 6:40 P.M., from the causes and on the date stated above.

SIGNATURE Lauren Manganov M.D. ADDRESS Cambridge, Md DATE SIGNED 5/26/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>5-28-1955</u>	NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Park</u>	LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>
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DATE REC'D BY LOCAL REGISTRAR <u>May 28, 1955</u>	REGISTRAR'S SIGNATURE <u>John Mace m.d.</u>	24. FUNERAL DIRECTOR ADDRESS <u>LeCompte Funeral Service Cambridge, Maryland</u>
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MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

S. A. OVER

THE

4609

04604  
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** No. ....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR			
13 TOWN <u>Cambridge</u>		7 years		TOWN <u>Cambridge</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>116 Locust St.</u>				STREET ADDRESS (If rural, give location) <u>116 Locust St.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
(Type or Print) <u>Francis Arthur Laskowski</u>				<u>May 2, 1955</u> 19			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Widowed</u>	<u>Dec. 9, 1887</u>	<u>67</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Unemployment Office</u>				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Brooklyn, N.Y.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME: <u>Henry M. Laskowski</u>			
14. MOTHER'S MAIDEN NAME: <u>Jennie Gleason</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY No.: <u>219-03-1739</u>				17. INFORMANT & ADDRESS: <u>Edw. H. Laskowski, 116 Locust St., Cambridge</u>			

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				died in sleep	
420.1 Immediate cause (a) <u>Coronary occlusion</u> DUE TO					
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO					
stating underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>John Mace</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM.		DATE SIGNED <u>5-3-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF <u>May 4, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Kenwood Park</u>	LOCATION (City, town, or county) <u>Cambridge, Md.</u>	(State)	
DATE REC'D BY LOCAL REG. <u>May 3, 1955</u>	REGISTRAR'S SIGNATURE <u>John Mace, M.D.</u>	24. FUNERAL DIRECTOR <u>Kenneth R. Thomas, Cambridge, Md.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

S. A. STYME

10-31

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# 462 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04605  
Reg. Dist.

No. 116.....

## I. PLACE OF DEATH:

COUNTY Dorchester

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)  
TOWN CambridgeLENGTH OF STAY  
(in this place)  
8 weeks 3 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY WicomicoCITY (If outside corporate limits write RURAL and give nearest town)  
OR  
TOWN Rural Salisbury 22X-2HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS Eastern Shore State HospitalSTREET  
ADDRESS (If rural, give location)  
Pineway Route 5 ✓3. NAME OF  
DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

CharlesSamuelLayfield4. DATE  
OF  
DEATH

(Month)

(Day)

(Year)

May81955

## 5. SEX:

Male6. COLOR OR  
RACE:White7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify)Married

## 8. DATE OF BIRTH:

July 8, 1927

## 9. AGE last birthday:

27 yrs.

## IF UNDER 1 YEAR

Months

Days

## IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of  
work done during most of work life,  
even if retired):Service Station attend.10b. KIND OF BUSINESS OR  
INDUSTRY:Automotive

## 11. BIRTHPLACE (State or foreign country):

Delmar Maryland12. CITIZEN OF WHAT  
COUNTRY?U.S.A.

## 13. FATHER'S NAME:

Clayton Layfield

## 14. MOTHER'S MAIDEN NAME:

Mary Layfield (maiden name unknown)15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates of  
service)No

## 16. SOCIAL SECURITY No.:

unknown

## 17. INFORMANT &amp; ADDRESS:

Eastern Shore State Hospital Records

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

(a).....

Coronary Occlusion

DUE TO

Antecedent cause(s)

Diseases or conditions, if any,  
giving rise to the above cause

(b).....

Diabetes Mellitus

DUE TO

stating underlying cause last

(c)

INTERVAL BETWEEN  
ONSET AND DEATH1 hr.2 yrs.II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.Acute Brain Syndrome withMetabolic Disturbance3 yrs.

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDING OF OPERATION:

## 20. AUTOPSY?

Yes ☐ No ☐21a. EXTERNAL CAUSE WAS  
PRIMARY ☐ or CONTRIBUTING ☐  
CAUSE OF DEATH.21b. PLACE (Home, farm, factory,  
OF street, office bldg., etc.,  
INJURY

## 21c. (City or town),

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour)  
OF  
INJURY

M.

21e. INJURY OCCURRED  
While at Not while  
work ☐ at work ☐

## 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

John Mace, Jr.

CHIEF MEDICAL EXAMINER

DATE SIGNED

DEPUTY MEDICAL EXAMINER

May 8, 1955

M. D.

ASSISTANT MEDICAL EXAM.

23. BURIAL, CREMATION,  
REMOVAL (Specify):Burial

## DATE THEREOF

5-10-55

## NAME OF CEMETERY

LeGates

## LOCATION (City, town, or county)

Delmar, Del.

(State)

DATE REC'D BY LOCAL  
REG.May 10, 1955

## REGISTRAR'S SIGNATURE

John Mace, Jr. M.D.

## 24. FUNERAL DIRECTOR

W. S. Spaul Co. Delmar, Del.

## ADDRESS

100



4610

## CERTIFICATE OF DEATH

Reg. Dist. No. 116 ...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u> <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
13 TOWN <u>Cambridge</u>		life		Oxford		2' X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Passwater Convelesent Home</u>				STREET ADDRESS (If rural give location) P.O.			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
SARA C. LONG				OF DEATH. MAY 15 19 55			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
Female		White		widowed		11-12-1872	
9. AGE last birthday		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10a. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
82 yrs.		Housewife		Own Home		Maryland	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	
U.S.A.		George T. Swain		Mary L. Williams		no	
16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
none		Mrs. Irene Schult; Baltimore, Md.		I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		2 days	
				331X IMMEDIATE CAUSE (A) Cerebral Hemorrhage			
				ANTECEDENT CAUSE (B) Generalized Atherosclerosis		?	
				DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
				(C)			
				II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
0							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 5/14/55, 19, to 5/15, 1955, that I last saw the deceased alive on 5/15, 1955, and that death occurred at 11:10 P.M. from the causes and on the date stated above.							
SIGNATURE		M. D.		ADDRESS		DATE SIGNED	
Lawrence Maryanov				Cambridge, Md		5/26/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		5-18-1955		St. Carmel Cemetery		Baltimore, Maryland	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
5-18-55		John Mace, M.D.		LeCompte Funeral Service		Cambridge, Maryland	

MARGIN RESERVED FOR BINDING

VS. A15-10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 28 19

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4611

CERTIFICATE OF DEATH

Reg. Dist. No. 04607

1. PLACE OF DEATH.				2. USUAL RESIDENCE (HOME) OF DECEASED.			
COUNTY <u>Dorchester</u> MARYLAND				STATE <u>Maryland</u> COUNTY <u>Dor.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cambridge</u>		LENGTH OF STAY (in this place) <u>60 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cambridge</u> <u>13</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cambridge-Maryland Hospital</u>				STREET ADDRESS (If rural give location) <u>214 Henry Street.</u> <u>1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <u>Oscar</u> <u>Percy</u> <u>Lyons Sr.</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>May 24, 1955</u> <u>19</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>Jan. 11, 1881</u>	9. AGE last birthday: <u>74</u> yrs.	IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Retired Grocer, self employed</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Oxford, Md.</u>	
13. FATHER'S NAME: <u>Thomas Lyons</u>				14. MOTHER'S MAIDEN NAME: <u>Nancy Isles</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS: <u>Nora M. Lyons, 214 Henry St., Cambridge, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Uremia</u>						<u>5 days</u>	
ANTECEDENT CAUSE (B) <u>Cardio-renal Uremia</u>						<u>2 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Chronic renal failure</u>						<u>3 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Hypertension</u>							
19A. DATE OF OPERATION: <u>no</u>		19B. MAJOR FINDINGS OF OPERATION: <u>no</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5-11</u> , 19 <u>55</u> , to <u>5-24</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5-24</u> , 19 <u>55</u> , and that death occurred at <u>4:30 P.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		ADDRESS <u>[Address]</u>		DATE SIGNED <u>[Date]</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 26, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Greenlawn</u>		LOCATION (City, town, or county) (State) <u>Cambridge, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>May 26, 1955</u>		REGISTRAR'S SIGNATURE <u>John Mace Jr. M.D.</u>		24. FUNERAL DIRECTOR ADDRESS <u>Kenneth R. Thomas, Cambridge, Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

ROBERT V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 116

4612

04608

1. PLACE OF DEATH COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Maryland</b> COUNTY <b>Dor</b>	
CITY (If outside corporate limits, write RURAL end give nearest town) TOWN <b>Cambridge</b>		CITY (If outside corporate limits, write RURAL end give nearest town) TOWN <b>Cambridge</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Cambridge Md Hospital</b>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <b>Donald</b>		4. DATE OF DEATH (Month) <b>May</b> (Day) <b>3</b> (Year) <b>19 55</b>	
(First) <b>Donald</b> (Middle) <b>Donel</b> (Last) <b>Macer</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Single</b>	8. DATE OF BIRTH <b>4-10-55</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE last birthday yrs. <b>24</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>Arthur Macer</b>		14. MOTHER'S MAIDEN NAME <b>Alene Stanley</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No. <b>--</b>	
		17. INFORMANT <b>Mrs Alene Macer-Madison, Md.</b>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
<b>762.5</b> Immediate cause (a) <b>Premature</b> Antecedent cause(s) (b) <b>Pulmonary congestion</b> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <b>Cerebral damage due to anoxemia</b>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Apr. 10, 1955**, to **May 3, 1955**, that I last saw the deceased alive on **May 3, 1955**, and that death occurred at **7 P.m.**, from the causes and on the date stated above.

SIGNATURE **J. Edwin Fassett** (Degree or title) ADDRESS **227 Pine St-Camb., Md** DATE SIGNED **May 4, 1955**

23. BURIAL, CREMATION REMOVAL (Specify) **Burial** DATE **5/5/1955** NAME OF CEMETERY OR CREMATORY **Madison Cemetery** LOCATION (City, town, or county) (State) **Madison, Maryland**

DATE REC'D BY LOCAL REG. **May 5, 1955** REGISTRAR'S SIGNATURE **John Macer Jr. M.D.** 24. FUNERAL DIRECTOR **Herbert M. St. Clair, Jr.** ADDRESS **Cambridge, Md.**

2045271392

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04609

4613

## CERTIFICATE OF DEATH

Reg. Dist. No. .... 1.6 .....

1. PLACE OF DEATH- COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Dor</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cambridge</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cambridge</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cambridge Md Hospital</u>		STREET ADDRESS (If rural, give location) <u>8 Wright Street</u>	
3. NAME OF DECEASED (First) <u>Tevis</u> (Middle) <u>Laverne</u> (Last) <u>Matthews</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>3</u> (Year) <u>19 55</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>- - -</u>	8. DATE OF BIRTH <u>Apr-19-55</u>
9. AGE last birthday <u>13</u> yrs. If under 1 year Months <u>15</u> Days <u>15</u> Hours <u>15</u> Min.		10. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Reginald Sharp</u>		14. MOTHER'S MAIDEN NAME <u>Mildred Matthews</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>- - -</u>		16. SOCIAL SECURITY No. <u>- - -</u>	
17. INFORMANT AND ADDRESS <u>8 Wright St</u> <u>Mildred Matthews-</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Inanition</u>		
Antecedent cause(s) (b) <u>Bronchopneumonia</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u> <u>HOMICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 2, 1955, to May 3, 1955, that I last saw the deceased alive on May 3, 1955, and that death occurred at 12:50A m., from the causes and on the date stated above.

SIGNATURE

ADDRESS

DATE SIGNED

J. EDWIN FASSETT, M.D.-227 Pine St-Camb., Md.-May 4, 1955

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>5/5/1955</u>	NAME OF CEMETERY OR CREMATORY <u>Waugh Cemetery</u>	LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>
DATE REC'D BY LOCAL REG. <u>May 5, 1955</u>	REGISTRAR'S SIGNATURE <u>John Maw, M.D.</u>	24. FUNERAL DIRECTOR <u>Herbert M. St. Clair, Jr., Cambridge, Md.</u>	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

3 1/2 1/2 1/2



## CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Baltimore</i>	MARYLAND	STATE <i>Md.</i>	COUNTY <i>Talbot</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>13 Cambridge</i>	LENGTH OF STAY (in this place) <i>3 days</i>	CITY (If outside corporate limits, write RURAL and give nearest town) <i>13 Trappe</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>90 Glenburne Court Home</i>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (Type or Print) <i>William R. Mc Guffin</i>		4. DATE OF DEATH (Month) (Day) (Year) <i>May 30 1955</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <i>Married</i>	8. DATE OF BIRTH <i>July 8, 1888</i>
9. AGE last birthday <i>66</i> years		10. MONTHS <i>6</i> Days <i>30</i> Hours <i>19</i> Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Command artist</i>	
11. BIRTHPLACE (State or foreign country) <i>Balt</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Wm. R. Mc Guffin</i>		14. MOTHER'S MAIDEN NAME <i>Hellie Kultz</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If Yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>208-03-1536-A</i>	
17. INFORMANT & ADDRESS <i>Mrs. Nellie Mc Guffin</i>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE <i>420.0</i>		(A) <i>Stroke</i> <i>Coronary Occlusion</i>	
ANTECEDENT CAUSE (S):		DUE TO <i>Parkinson's Disease</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B) <i>Arteriosclerotic Heart Disease</i>	
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <i>U</i>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>5/27, 1955</i> to <i>5/30, 1955</i> that I last saw the deceased alive on <i>5/30, 1955</i> , and that death occurred at <i>7:10 AM</i> , from the causes and on the date stated above.			
SIGNATURE <i>Lawrence Maryanor</i>		ADDRESS <i>M. D. Cambridge, Md</i>	
DATE SIGNED <i>6/2/55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Buried</i>		DATE THEREOF <i>6-1-55</i>	
NAME OF CEMETERY OR CREMATORY <i>Spring Hill Cem.</i>		LOCATION (City, town, or county) (State) <i>Easton Talbot Md</i>	
DATE REC'D BY LOCAL REGISTRAR <i>6-1-55</i>		REGISTRAR'S SIGNATURE <i>John Mace M.D.</i>	
24. FUNERAL DIRECTOR <i>Thomson &amp; Newman</i>		ADDRESS <i>Don</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



4614

## CERTIFICATE OF DEATH

Reg. Dist. No. 416

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY	Dorchester	STATE	Maryland
CITY (If outside corporate limits, write RURAL and give nearest town)	Cambridge	COUNTY	Dor
OR TOWN	Cambridge	CITY (If outside corporate limits, write RURAL and give nearest town)	Cambridge
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Cambridge Md Hospital	STREET ADDRESS	147 Washington St
3. NAME OF DECEASED:	(First)	(Middle)	(Last)
(Type or Print)	Rhoda		Meekins
5. SEX:	Female	8. DATE OF BIRTH:	May 5, 1896
5. COLOR OR RACE:	Negro	9. AGE last birthday:	58 yrs. 11 Months 29 Days
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	Widow	10. DATE OF BIRTH:	May 5, 1896
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):	Housewife	11. BIRTHPLACE (State or foreign country):	Dorchester County, Md.
10b. KIND OF BUSINESS OR INDUSTRY:	Home	12. CITIZEN OF WHAT COUNTRY?	USA
13. FATHER'S NAME:	Abraham Lane	14. MOTHER'S MAIDEN NAME:	Mary Mc Namara
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	-----	16. SOCIAL SECURITY No.:	213-12-5899
(If Yes, give war or dates of service)	-----	17. INFORMANT & ADDRESS:	Mrs. Edith Rasin, New York City, N.Y.

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
420.1 Immediate cause		
(a)	Coronary insufficiency	
DUE TO		
Antecedent causes(s)		
(b)	Myocardial infarction	
DUE TO		
(c)	Cardiac Decompensation	

11. OTHER SIGNIFICANT CONDITIONS		
Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY ?
6		Yes <input type="checkbox"/> No <input type="checkbox"/>

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR ?		

22. I hereby certify that I attended the deceased from April 19, 1955, to May 4, 1955, that I last saw the deceased alive on May 4, 1955, and that death occurred at \_\_\_\_\_, from the causes and on the date stated above.

23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial		5/8/1955	Bethel Cemetery	Cambridge, Maryland	
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS			
May 5, 1955	John Maw, Jr. M.D.	Herbert M. St. Clair, Jr., Cambridge, Md.			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BOYD V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04612

4628

## CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u> MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Ocean City</u> 32X-2		STREET ADDRESS (If rural give location) <u>Route # 1</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cambridge</u> 14-5120124		LENGTH OF STAY (in this place)		HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eastern Shore State Hospital</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH: (Month) (Day) (Year)		5. SEX:		6. AGE last birthday: (If UNDER 1 YEAR) (If UNDER 24 HRS.)	
<u>Sumner</u> <u>Nichols</u>		<u>May</u> <u>6</u> <u>1955</u>		<u>M</u>		<u>83</u> yrs. <u>11</u> Months <u>15</u> Days <u></u> Hours <u></u> Min.	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>W</u>		8. DATE OF BIRTH: <u>May 18 1871</u>		9. AGE last birthday: <u>83</u>		10. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>W</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>W</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>W</u>				14. MOTHER'S MAIDEN NAME: <u>W</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u></u>		17. INFORMANT & ADDRESS: <u>Hospital Records</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u></u>		17. INFORMANT & ADDRESS: <u>Hospital Records</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
332X Immediate cause (a) <u>Cerebral Thrombosis</u> <u>W</u>							
Antecedent causes (s) (b) <u>Cerebral Arteriosclerosis</u> <u>W</u>							
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <u></u>							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <u>None</u>				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>None</u>		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 24, 1953</u> , to <u>May 6, 1955</u> , that I last saw the deceased alive on <u>May 6, 1955</u> , and that death occurred at <u>9:25 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Thomas J. Dudgeon M.D.</u>				ADDRESS <u>State Hosp. Cambridge Md.</u> DATE SIGNED <u>May 6 '55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>5/9/55</u>		NAME OF CEMETERY OR CREMATORY <u>PARSONS CEM.</u>		LOCATION (City, town, or county) (State) <u>Salisbury Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5-9-55</u>		REGISTRAR'S SIGNATURE <u>John Maw. m.d.</u>		24. FUNERAL DIRECTOR <u>Will Johnson Co.</u>		ADDRESS <u>Franklin's Hill</u>	

EDWARD V. S.

1914

1914

4629

## CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH.				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u> MARYLAND				STATE <u>Maryland</u> COUNTY <u>Dorchester</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>Cambridge (Rural)</u> LENGTH OF STAY (in this place) <u>life</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cambridge (Rural)</u> <u>X</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS (Cornersville RFD#3)				STREET ADDRESS (If rural give location) (Cornersville RFD#3)			
3. NAME OF DECEASED: (First) MARY (Type or Print)		(Middle) E.		(Last) NORTH		4. DATE (Month) (Day) (Year) OF DEATH: MAY 27 1955	
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed	8. DATE OF BIRTH: 1-7-1863		9. AGE last birthday: 92 yrs.	10. IF UNDER 1 YEAR: Months Days Hours Mln.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife		10B. KIND OF BUSINESS OR INDUSTRY: Own Home		11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: John N. North				14. MOTHER'S MAIDEN NAME: Jane B. Frazier			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT & ADDRESS: Milton North: Cambridge RFD#3 Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Carcinoma Desc. Colon</u>						1 year	
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>arteriosclerotic CVR Disease</u>						5 yrs +	
19A. DATE OF OPERATION: <u>None</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-20</u> , 19 <u>46</u> , to <u>5-27</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5-25</u> , 19 <u>55</u> , and that death occurred at <u>7:30 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Eldridge H. W. Jeff</u>		M. D.		ADDRESS		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5-30-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5-30-55</u>		REGISTRAR'S SIGNATURE <u>John Maw. M.D.</u>		24. FUNERAL DIRECTOR <u>LeCompte Funeral Service</u>		ADDRESS <u>Cambridge, Maryland</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. A. 10. 10. 10. 10.

6. 10. 10.

1. 10. 10. 10. 10.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04614

4615

## CERTIFICATE OF DEATH

Reg. Dist. No. .... 116

1. PLACE OF DEATH- COUNTY <u>Dorchester</u> CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Cambridge</u> TOWN <u>Cambridge</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cambridge Med Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD</u> COUNTY <u>DORCHESTER</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Harlock</u> TOWN <u>Harlock</u> STREET ADDRESS (If rural, give location) <u>WEBSTER ST</u>	
3. NAME OF DECEASED (Type or Print) <u>ALICE</u> (First) <u>JANE</u> (Middle) <u>PHILLIPS</u> (Last)		4. DATE OF DEATH (Month) <u>5</u> (Day) <u>19</u> (Year) <u>1955</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>married</u>	8. DATE OF BIRTH <u>Dec 19, 1906</u>
9. AGE last birthday <u>49</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>MD</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>ARTHUR ESKRIDGE</u>		14. MOTHER'S MAIDEN NAME <u>FLORANCE WHEATLEY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>180-160 112</u>	
17. INFORMANT AND ADDRESS <u>HERMAS PHILLIPS</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

4- Immediate cause (a) -- Coronary occlusion

## Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Hypertension, essential

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒21. ACCIDENT  
SUICIDE  
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)  
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 12, 1953, to May 19, 1955, that I last saw the deceasedalive on May 18, 1955, and that death occurred at 6:15 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Alfred R. MaryanorM.D.136 Race St, Cambridge5/19/5523. BURIAL, CREMATION  
REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL  
REG.

## REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

ADDRESS

May 22, 1955John Maw, M.D.Paul G. Smith, Hagerstown, Md

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

EDWARD V. S.

MAY 20 1911

RECEIVED

4616

## CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL, OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
13 TOWN <u>Cambridge</u>				OR TOWN <u>Bishops Head</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Appleby Avenue</u>				STREET ADDRESS (If rural give location) <u>P.O.</u> 1			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
(Type or Print) <u>ADA MEREDITH PRITCHEST</u>				OF DEATH: <u>MAY 24 19 55</u>			
5. SEX.	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS	
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>1-9-1895</u>	<u>60</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>							
13. FATHER'S NAME: <u>Millard Meredith</u>				14. MOTHER'S MAIDEN NAME: <u>Georgia Parks</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS: <u>Marcella Tolley : Fishing Creek, Md.</u>	
18. MEDICAL CERTIFICATION							
DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>434.1</u>							
IMMEDIATE CAUSE (A)				DUE TO <u>GASTROINTESTINAL HEART FAILURE</u> 1 YEAR			
ANTECEDENT CAUSE (B)				DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				DUE TO			
(C)				DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>30 JAN, 1955</u> , to <u>24 MAY, 1955</u> , that I last saw the deceased alive on <u>24 MAY, 1955</u> and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Halter E. Hunsby Jr.</u>				ADDRESS <u>M.D. Cambridge Md.</u>		DATE SIGNED <u>26 MAY 1955</u>	
23 BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5-27-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>May 27, 1955</u>		REGISTRAR'S SIGNATURE <u>John Mace, Jr. M.D.</u>		24 FUNERAL DIRECTOR <u>LeCompte Funeral Service</u>		ADDRESS <u>Cambridge, Maryland</u>	

MARGIN RESERVED FOR BINDING

U.S. AIR FORCE

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10-1

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

04616

Reg. Dist. No. 116

4630

1. PLACE OF DEATH COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> TOWN <u>Cambridge (Rural)</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cambridge (Rural)</u> <input checked="" type="checkbox"/>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>RFD# 3</u>		STREET ADDRESS <u>RFD # 3</u> (If rural give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>W.</u> (Middle) <u>RUSSELL</u> (Last) <u>SEWARD</u>	4. DATE OF DEATH (Month) <u>MAY</u> (Day) <u>11</u> (Year) <u>1955</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>12-21-1895</u>
9. AGE last birthday <u>59</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles N. Seward</u>		14. MOTHER'S MAIDEN NAME <u>Evelyn Rumbley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>218-34-7768</u>	
17. INFORMANT <u>Mrs. Anita N. Seward: Cambridge RFD# 3., Md.</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		15. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause <u>Metastatic carcinoma</u>		Antecedent cause(s) <u>Lymph glands. Right Testis</u>		<u>1 week</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>Carcinoma of Rectum</u>				<u>1 1/2 yrs.</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION <u>July 1 - 1954</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of Rectum</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>no</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>no</u>		CITY OR TOWN (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>no</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR? <u>no</u>	
22. I hereby certify that I attended the deceased from <u>May 15, 1955</u> , to <u>May 11, 1955</u> , that I last saw the deceased alive on <u>May 10, 1955</u> , and that death occurred at <u>3 P.M.</u> , from the causes and on the date stated above.					
SIGNATURE <u>John Mace Jr. M.D.</u>		(Degree or title)		ADDRESS <u>Cambridge Md</u> DATE SIGNED <u>May 14 1955</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>5-13-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>	
LOCATION (City, town, or county) <u>Cambridge, Maryland</u>		(State)			
DATE REC'D BY LOCAL REG. <u>May 14, 1955</u>		REGISTRAR'S SIGNATURE <u>John Mace Jr. M.D.</u>		24. FUNERAL DIRECTOR <u>Le Oppte Funeral Service</u>	
ADDRESS <u>Cambridge, Maryland</u>					

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

40

40

BUREAU V. B.

1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4631

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04617

## CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		STATE <u>Maryland</u>		COUNTY <u>Talbot</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (If this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Cambridge</u>		<u>since 7/21/54</u>		TOWN <u>St. Michaels</u>		<u>Box 2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eastern Shore State Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Lee Roland Swanhouse</u>				<u>May 16 19 55</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>		8. DATE OF BIRTH: <u>April 17, 1898</u>	
				9. AGE last birthday <u>57</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Carpenter</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Construction</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
13. FATHER'S NAME: <u>William Swanhouse</u>				14. MOTHER'S MAIDEN NAME: <u>Elizabeth (last name unknown)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>WAR II</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>Eastern Shore State Hospital Records</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Bronchopneumonia</u>						<u>2 days</u>	
ANTECEDENT CAUSE (B) <u>Carcinoma of the pelvis with Metastasis</u>						<u>unknown</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>(307x)</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Psychosis due to Alcohol</u>						<u>18 months</u>	
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7/21</u> , 19 <u>54</u> , to <u>5/16</u> , 19 <u>55</u> that I last saw the deceased alive on <u>5/16</u> , 19 <u>55</u> , and that death occurred at <u>4:30 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Robert H. Reddick</u>		ADDRESS <u>Cambridge, Maryland</u>		DATE SIGNED <u>May 16, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 18, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Christ Cemetery</u>		LOCATION (City, town, or county) <u>St. Michaels, Md</u> (State)	
DATE REC'D BY LOCAL REGISTRAR <u>May 18, 1955</u>		REGISTRAR'S SIGNATURE <u>John M. M.D.</u>		24. FUNERAL DIRECTOR <u>St. Michaels</u>		ADDRESS <u>St. Michaels, Md</u>	

BUREAU V. 1

1905

RECEIVED



4617

## CERTIFICATE OF DEATH

Reg. Dist. No. 116.....

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY	Dorchester		STATE	Maryland	
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR		
TOWN	Cambridge		TOWN	Cambridge	
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS (If rural give location)		
211 Willis Street			211 Willis Street		
3. NAME OF DECEASED:			4. DATE (Month) (Day) (Year)		
(First)	(Middle)	(Last)			
(Type or Print)	ETHEL TYLER	TALL	DATE OF DEATH: MAY 24 1955		
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:		
Female	White	Widowed	3-29-1898		
9. AGE last birthday			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		
57 yrs.			Housewife		
11. BIRTHPLACE (State or foreign country):			12. CITIZEN OF WHAT COUNTRY?		
Maryland			U.S.A.		
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME:		
Harry Tyler			Elizabeth Wallace		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
no			218-24-2677		
17. INFORMANT & ADDRESS:					
Mrs. Reginald Brooks: Cambridge, Maryland					

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
X IMMEDIATE CAUSE (A) <u>Gleoma - (Brain tumor)</u>		2 mos
ANTECEDENT CAUSE (S) DUE TO		
(B) DUE TO		
(C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
	<u>Gleoma - Rt. Frontal lobe</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-19-55, 19...., to 5-24, 1955, that I last saw the deceased alive on 5-24-55, 19...., and that death occurred at 8<sup>50</sup>/<sub>4</sub> M, from the causes and on the date stated above.

SIGNATURE W. Baumann M. D. ADDRESS Cambridge DATE SIGNED 5-26-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	5-26-1955	Dorchester Memorial Park	Cambridge, Maryland

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
May 26, 1955	John Mace, Jr. M.D.	LeCompte Funeral Service Cambridge, Maryland

MARGIN RESERVED FOR BINDING

VS. A15-10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY

19

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4618

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04619

## CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>Dorchester</b>	MARYLAND	STATE <b>Maryland</b>	COUNTY <b>Dorchester</b>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
<b>13</b> TOWN <b>Cambridge</b>	<b>7 days</b>	OR TOWN <b>East New Market - Rural</b> <b>X</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Cambridge - Maryland Hospital</b>		STREET ADDRESS (If rural give location) <b>Thompstontown</b>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH:	
<b>Joshua John Wesley Thomas</b>		<b>May 22 1955</b>	
5. SEX: <b>Male</b>	6. COLOR OR RACE: <b>Colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH: <b>May 18, 1902</b>
9. AGE last birthday <b>53</b> yrs.		10. UNDER 1 YEAR 11. UNDER 24 HRS. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Farm Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>Farm</b>	
11. BIRTHPLACE (State or foreign country): <b>Dorchester Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME: <b>John W. Thomas</b>		14. MOTHER'S MAIDEN NAME: <b>Mary Jane Denby</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>3 No</b> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>213-14-6088</b>	
17. INFORMANT & ADDRESS: <b>Annie Thomas, East New Market, Md., RFD</b>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
420.1 IMMEDIATE CAUSE (A) <b>Myocardial Failure</b>		<b>8 hours</b>	
ANTECEDENT CAUSE (B) <b>Coronary artery disease</b>		<b>?</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>Postoperative Appendectomy</b>		<b>7/17/55</b>	
19A. DATE OF OPERATION: <b>1/17/55</b>		19B. MAJOR FINDINGS OF OPERATION: <b>Retrocecal acute appendicitis</b>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>5/16</b> , 19 <b>55</b> , to <b>5/22</b> , 19 <b>55</b> , that I last saw the deceased <b>alive/on</b> and that death occurred at <b>2:10 AM</b> from the causes and on the date stated above.			
SIGNATURE <b>[Signature]</b>		ADDRESS <b>Cambridge Md</b> DATE SIGNED <b>5/24/55</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>May 25, 1955</b>	
NAME OF CEMETERY OR CREMATORY <b>Thompstontown Cemetery</b>		LOCATION (City, town, or county) (State) <b>Near East New Market, Md.</b>	
DATE REC'D BY LOCAL REGISTRAR <b>May 25, 1955</b>		REGISTRAR'S SIGNATURE <b>[Signature]</b>	
24. FUNERAL DIRECTOR <b>J.J. Frampton and Son, Federalsburg, Md.</b>		ADDRESS	



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04660

4632

## CERTIFICATE OF DEATH

Reg. Dist. No. 113

1. PLACE OF DEATH.				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Dorchester</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Golden Hill</u>		LENGTH OF STAY (in this place) <u>40 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Golden Hill</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED: (Type or Print) (First) <u>Amos</u> (Middle) <u>H.</u> (Last) <u>Travers</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>May 14</u> 19 <u>55</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Neep</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH: <u>May 12 1888</u>	9. AGE last birthday <u>67</u>	IF UNDER 1 YEAR Months <u>57</u> Days <u>10</u> Hours <u>22</u> Min. <u>—</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Sea Food</u>		11. BIRTHPLACE (State or foreign country): <u>Dorchester Co. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Jacob Travers</u>				14. MOTHER'S MAIDEN NAME: <u>Mary M. Johnson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>1</u>				16. SOCIAL SECURITY NO. <u>213-24-4445</u>		17. INFORMANT & ADDRESS: <u>Christina Ellis, Cambridge Md</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Diabetic Mellitus</u>						1 month	
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>home</u>							
19A. DATE OF OPERATION: <u>None</u>				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>May 5</u> , 1955, to <u>May 14</u> , 1955 that I last saw the deceased alive on <u>May 14</u> , 1955, and that death occurred at <u>9 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Amos W. Meade</u>				DATE SIGNED <u>5/16/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				DATE THEREOF <u>5/20/1955</u>		NAME OF CEMETERY OR CREMATORY <u>Taylor's Island</u>	
DATE REC'D BY LOCAL REGISTRAR <u>May 16/55</u>				REGISTRAR'S SIGNATURE <u>Amos W. Meade</u>		24. FUNERAL DIRECTOR <u>Herbert M. St. Clair, Jr.</u>	
						ADDRESS <u>Cambridge Md</u>	

RECEIVED

MAY 19 1964

RECEIVED

4619

## CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Dorchester</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Dorchester</b>	
CITY (if outside corporate limits, write RURAL and give nearest town) <b>13 TOWN Cambridge</b>		LENGTH OF STAY (in this place) <b>Life</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>OR TOWN Cambridge</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>618 High Street</b>				STREET ADDRESS (If rural give location) <b>Fairmount Avenue</b>			
3. NAME OF DECEASED: (First) <b>LEONARD</b> (Middle) <b>L</b> (Last) <b>TYLER</b>				4. DATE (Month) (Day) (Year) OF DEATH: <b>May 26, 1955</b>			
5. SEX: <b>Male</b>		6. COLOR OR RACE: <b>Negro</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Single</b>		8. DATE OF BIRTH: <b>March 23, 1881</b>	
9. AGE last birthday: <b>74</b> yrs.		10. UNDER 1 YEAR: Months		11. UNDER 24 HRS: Days		12. UNDER 24 HRS: Hours	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Laborer</b>				10B. KIND OF BUSINESS OR INDUSTRY: <b>Restaurant</b>		11. BIRTHPLACE (State or foreign country): <b>Cambridge, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME: <b>John Tyler</b>			
14. MOTHER'S MAIDEN NAME: <b>Mattie St. Clair</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>-----</b>			
16. SOCIAL SECURITY NO. <b>214-07-7821</b>				17. INFORMANT & ADDRESS: <b>Oree S. Tyler, Cambridge, Md</b>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <b>Broncho-oesophageal fistula</b>						10 days	
ANTECEDENT CAUSE (B) <b>Ca oesophagus</b>						10 mos	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>(1) Starvation (2) Congestive heart failure</b>							
19A. DATE OF OPERATION: <b>0</b>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>May 25, 1955</b> , to <b>May 26, 1955</b> , that I last saw the deceased alive on <b>May 25, 1955</b> , and that death occurred at <b>6 A.M.</b> from the causes and on the date stated above.							
SIGNATURE <b>James W. Thompson</b>				ADDRESS <b>Cambridge, Md.</b>		DATE SIGNED <b>May 30, 1955</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>5/30/1955</b>		NAME OF CEMETERY OR CREMATORY <b>Waugh Cemetery</b>		LOCATION (City, town, or county) (State) <b>Cambridge, Maryland</b>	
DATE REC'D BY LOCAL REGISTRAR <b>May 30, 1955</b>		REGISTRAR'S SIGNATURE <b>John Mace, Jr. M.D.</b>		24. FUNERAL DIRECTOR ADDRESS <b>Herbert M. St. Clair, Jr., Cambridge, Md.</b>			

MARGIN RESERVED FOR BINDING

5 A 107802

1956





## CERTIFICATE OF DEATH

04622  
Reg. Dist. No. 116

4633

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Dorchester</u> MARYLAND	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Crisfield</u>	STATE <u>Maryland</u> COUNTY <u>Somerset</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Crisfield</u>
CITY <u>Crisfield</u> OR TOWN <u>Crisfield</u>	LENGTH OF STAY (in this place) <u>14 days 9 months</u>	OR TOWN <u>Crisfield</u>	OR TOWN <u>Crisfield</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>State Hospital</u>	STREET ADDRESS (If rural give location) <u>Crisfield</u>	STREET ADDRESS (If rural give location) <u>Crisfield</u>	STREET ADDRESS (If rural give location) <u>Crisfield</u>
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH: (Month) (Day) (Year)	
<u>Mary Elizabeth Taylor</u>		<u>May 6 1955</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>S</u>	8. DATE OF BIRTH: <u>July 4 1901</u>
9. AGE last birthday: <u>53</u> yrs. <u>10</u> months <u>2</u> days <u>2</u> hours <u>2</u> min.		10. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>None</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Wink</u>		14. MOTHER'S MAIDEN NAME: <u>Wink</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY No.: <u>None</u>	
17. INFORMANT & ADDRESS: <u>Hospital Records</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death	
153X Immediate cause		<u>Wink</u>	
(a) <u>Shock due to perforation of Adenocarcinoma of Ascending Colon</u>		<u>Wink</u>	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.		<u>Wink</u>	
(b) <u>General Peritonitis</u>		<u>Wink</u>	
(c) <u>General Peritonitis</u>		<u>Wink</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
19a. DATE OF OPERATION: <u>May 6 1955</u>		19b. MAJOR FINDINGS OF OPERATION: <u>Carcinoma Perforation, Peritonitis</u>	
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>None</u>		PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from <u>Jan 1, 1955</u> , to <u>May 6, 1955</u> , that I last saw the deceased alive on <u>May 6, 1955</u> , and that death occurred at <u>10:08 PM</u> from the causes and on the date stated above.	
SIGNATURE <u>Thomas D. Dudge</u> (Degree or title)		ADDRESS <u>120 State Hosp. Cambridge Md</u> DATE SIGNED <u>May 6 55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>May 11, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Asbury Cemetery</u>		LOCATION (City, town, or county) (State) <u>Crisfield, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>May 12 1955</u>		REGISTRAR'S SIGNATURE <u>John MacFarlane</u>	
FUNERAL DIRECTOR <u>Bradshaw &amp; Sons</u>		ADDRESS <u>531 Main Street Crisfield, Maryland</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

EMMA A. S.

MAY

PROCTOR

4620

## CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Easton</u> <u>20.40.8</u>			
13 TOWN <u>Cambridge</u>				STREET ADDRESS (If rural give location)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cambridge Maryland Hospital</u>				ADDRESS			
3. NAME OF DECEASED: (Type or Print) <u>ANN</u>		(First) <u>B.</u>		(Middle) <u>VALLIANT</u>		(Last)	
4. DATE OF DEATH: <u>MAY</u> <u>28</u> <u>1955</u>		(Month) <u>MAY</u>		(Day) <u>28</u>		(Year) <u>1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE MARRIED, WIDOWED, DIVORCED, (Specify): <u>Divorced</u>	8. DATE OF BIRTH: <u>1-21-1869</u>	9. AGE last birthday: <u>86</u> yrs.	10. UNDER 1 YEAR: Months	11. UNDER 24 HRS: Days	12. UNDER 48 HRS: Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Domestic</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>		11. BIRTHPLACE (State or foreign country): <u>Delaware</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME: <u>Thomas S. Sutcliffe</u>				14. MOTHER'S MAIDEN NAME: <u>Susan Holding</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS: <u>W. Enos Valliant: Cambridge, Maryland</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>PULMONARY EMBOLISM</u>				INTERVAL BETWEEN ONSET AND DEATH <u>30 SEC.</u>			
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8 APRIL, 1955</u> to <u>28 MAY, 1955</u> , that I last saw the deceased alive on <u>27 MAY, 1955</u> and that death occurred at <u>9:30 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Hetty E. Gunchy Jr.</u>		M.D. <u>Cambridge Md.</u>		DATE SIGNED <u>Dorch. County</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5-30-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Church Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Church Hill, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5-30-55</u>		REGISTRAR'S SIGNATURE <u>John Mace Jr. M.D.</u>		24. FUNERAL DIRECTOR <u>LeCompte Funeral Service</u>		ADDRESS <u>Cambridge, Maryland</u>	

MARGIN RESERVED FOR BINDING

RECEIVED

JUN

1964

4621

## CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY	Dorchester	STATE	Maryland
CITY (If outside corporate limits, write RURAL OR and give nearest town)	Cambridge	COUNTY	Dorchester
13. HOSPITAL OR INSTITUTION OR STREET ADDRESS	400 Willis Street	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	Cambridge
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
NETTIL HORSEMAN VANE		OF DEATH MAY 24 19 55	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
Female	White	Widowed	6-8-1366
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	9. AGE last birthday
Housewife		Own Home	88 yrs.
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Maryland		U.S.A.	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
Levin Wroten		Mary E. Wroten	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.	
no		no	
17. INFORMANT & ADDRESS: 4410 Groveland Aven George F. Vane E Baltimore, Maryland			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			1 day
IMMEDIATE CAUSE (A) DUE TO Cerebral hemorrhage			
ANTECEDENT CAUSE (B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
0			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 5/23, 1955, to 5/24, 1955, that I last saw the deceased alive on 5/24, 1955, and that death occurred at 11:15 A.M. from the causes and on the date stated above.			
SIGNATURE		ADDRESS	
Aldred R. Maryanov		M.D. 136 Race St, Cambridge	
DATE SIGNED		5/26/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
Burial		Greenlawn Cemetery	
DATE THEREOF		LOCATION (City, town, or county) (State)	
5-27-1955		Cambridge, Maryland	
DATE REC'D BY LOCAL REGISTRAR		FUNERAL DIRECTOR	
May 27, 1955		LeCompte Funeral Service	
REGISTRAR'S SIGNATURE		ADDRESS	
John M. ...		Cambridge, Maryland	

MARGIN RESERVED FOR BINDING

BUREAU V. S.

1955



4622

## CERTIFICATE OF DEATH

Reg. Dist. No. 116.....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
13 TOWN <u>Cambridge</u>		7 weeks		TOWN <u>Cambridge</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
67 <u>Cambridge Maryland Hospital</u>				RFD # 3			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
J. HILLERY WINGATE				MAY 4 1955			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Male	White	Married	11-28-1875	80 7/8 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Waterman		Fishing Indust.		Maryland		U.S.A.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Joseph E. Wingate				Laura Fallen			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
Unknown		none		Mr. Frank Wingate, Cambridge, Maryland			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) DUE TO						7 wks	
Congestive Heart Failure							
ANTECEDENT CAUSE (B) DUE TO						7 wks	
Coronary Atherosclerosis							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.						yrs.	
Arteriosclerotic C.V.D.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
0							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from March, 1955, to May 4, 1955, that I last saw the deceased alive on May 4, 1955, and that death occurred at 3:30 P.M. from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
W. Bannan		Cambridge		5-5-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		5-6-1955		Dorchester Memorial Parks		Cambridge, Maryland	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
May 10, 1955		John Macd. Jr. M.D.		LeCompte Funeral Service		Cambridge, Maryland	

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
MAY 11 1955  
BUREAU V. S.



4623

## CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) 13 TOWN <u>Cambridge</u>		LENGTH OF STAY (in this place) 6 months		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cambridge</u> 13			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 7 Travers Street				STREET ADDRESS (If rural give location) 7 Travers Street 1			
3. NAME OF DECEASED: (First) (Middle) (Last) B ESSIE WARNER WOLF				4. DATE (Month) (Day) (Year) OF DEATH: MAY 5 1955			
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: 2-16-1897	9. AGE last birthday 58 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife		10B. KIND OF BUSINESS OR INDUSTRY: Own Home		11. BIRTHPLACE (State or foreign country): Terre Haute, Ind.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: John Warner				14. MOTHER'S MAIDEN NAME: Not Known			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. none		17. INFORMANT & ADDRESS: Dr. Joseph Wolf: Cambridge, Maryland			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Coronary Thrombosis -</u>						<u>1/2 day</u>	
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5/4/55</u> , 19 <u>55</u> , to <u>5/5/55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5/4</u> 19 <u>55</u> and that death occurred at <u>M</u> , from the causes and on the date stated above. SIGNATURE <u>Edith B. Butler</u> ADDRESS <u>Cambridge, Md.</u> DATE SIGNED <u>5/6/55</u> M.D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 5-7-1955		NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park		LOCATION (City, town, or county) (State) Cambridge, Maryland	
DATE REC'D BY LOCAL REGISTRAR May 16, 1955		REGISTRAR'S SIGNATURE John Mace, Jr. B.H.		24. FUNERAL DIRECTOR LeCompte Funeral Service		ADDRESS Cambridge, Maryland	

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